		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045047

Facility Name: The Moorings Health Center

Address: 761 Old Barn Lane (Number) Arlington Heights (City) 60005 (Zip Code)

County: Cook

Telephone Number: 847.364-2435 **Fax #** 847.956-4495

IDPA ID Number: 36-2167832001

Date of Initial License for Current Owners: 10/1/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael Geraghty **Telephone Number:** 847.492-4873

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2000 to 3/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Peter Mulvey
(Title) President & C.E.O.

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	88	10,010	1
2		Skilled Pediatric (SNF/PED)			2
3	32	Intermediate (ICF)	32	5,824	3
4		Intermediate/DD			4
5	68	Sheltered Care (SC)	68	12,376	5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	28,210	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1,155		1,155	8
9	SNF/PED					9
10	ICF	1,441	16,142		17,583	10
11	ICF/DD					11
12	SC		7,993		7,993	12
13	DD 16 OR LESS					13
14	TOTALS	1,441	25,290		26,731	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.76%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/1/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 3/31/2001 Fiscal Year: 3/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	571,141	10,298	275,857	857,296		857,296	(47,232)	810,064			1
2	Food Purchase		261,453		261,453	(3,341)	258,112	(149,705)	108,407			2
3	Housekeeping	230,902	10,863	66,467	308,232		308,232	(209,598)	98,634			3
4	Laundry											4
5	Heat and Other Utilities			429,148	429,148		429,148	(291,821)	137,327			5
6	Maintenance	203,551	42,817	250,089	496,457		496,457	(341,495)	154,962			6
7	Other (specify):* Public Safety	92,357	4,543	25,935	122,835		122,835	(83,528)	39,307			7
8	**TOTAL General Services**	1,097,951	329,974	1,047,496	2,475,421	(3,341)	2,472,080	(1,123,379)	1,348,701			8
	B. Health Care and Programs											
9	Medical Director	21,202	163	22,500	43,865		43,865		43,865			9
10	Nursing and Medical Records	1,306,445	73,843	36,635	1,416,923	(3,983)	1,412,940		1,412,940			10
10a	Therapy	36,812	1,335	3,265	41,412		41,412		41,412			10a
11	Activities	103,388	14,224	13,890	131,502		131,502		131,502			11
12	Social Services	21,028	3,151	39,148	63,327		63,327		63,327			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,488,875	92,716	115,438	1,697,029	(3,983)	1,693,046		1,693,046			16
	C. General Administration											
17	Administrative	122,386		462,545	584,931	(124,144)	460,787	(276,848)	183,939			17
18	Directors Fees											18
19	Professional Services			32,443	32,443		32,443	(25,261)	7,182			19
20	Dues, Fees, Subscriptions & Promotions			27,315	27,315	124,144	151,459	(142,322)	9,137			20
21	Clerical & General Office Expenses	151,017	42,703	122,821	316,541		316,541	(222,469)	94,072			21
22	Employee Benefits & Payroll Taxes			605,065	605,065	3,341	608,406	(413,716)	194,690			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,598	6,598		6,598	(6,598)				25
26	Insurance-Prop.Liab.Malpractice			4,264	4,264		4,264	(2,900)	1,364			26
27	Other (specify):* Adult Day Care, Chapel			177,092	177,092		177,092	(177,092)				27
28	**TOTAL General Administration**	273,403	42,703	1,438,143	1,754,249	3,341	1,757,590	(1,267,206)	490,384			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,860,229	465,393	2,601,077	5,926,699	(3,983)	5,922,716	(2,390,585)	3,532,131			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Moorings Health Center #0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			525,313	525,313		525,313	(357,817)	167,496			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,021	102,021		102,021	(102,021)				32
33	Real Estate Taxes			625,845	625,845		625,845	(469,384)	156,461			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,253,179	1,253,179		1,253,179	(929,222)	323,957			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					3,983	3,983		3,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,132	49,132		49,132		49,132			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			49,132	49,132	3,983	53,115		53,115			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,860,229	465,393	3,903,388	7,229,010		7,229,010	(3,319,807)	3,909,203			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (142,240)	27	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(34,852)	27		4
5	Telephone, TV & Radio in Resident Rooms	(22,567)	21		5
6	Rented Facility Space	(4,488)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(102,021)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(6,598)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(122,763)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(146)	20		28
29	Other-Attach Schedule See Page 5A	(2,874,132)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,319,807)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (3,319,807)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		3,983	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 3,983		47

The Moorings Health Center

ID# 0045047

Report Period Beginning: 10/1/2000

Ending: 3/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Retirement Expense Dietary	$ (47,232)	1	1
2	Retirement Expense Food	(149,705)	2	2
3	Retirement Expense Housekeeping	(209,598)	3	3
4	Retirement Expense Utilities	(291,821)	5	4
5	Retirement Expense Maintenance	(334,539)	6	5
6	Retirement Expense Public Safety	(83,528)	7	6
7	Retirement Expense Administrative	(313,335)	17	7
8	Retirement Expense Legal	(15,261)	19	8
9	Retirement Expense Clerical	(199,902)	21	9
10	Retirement Expense Employee Benefits	(413,716)	22	10
11	Retirement Expense Insurance	(2,900)	26	11
12	Retirement Expense Depreciation	(357,817)	30	12
13	Retirement Expense Real Estate Tax	(469,384)	33	13
14	Retirement Expense not listed on page 5	(19,413)	20	14
15	Nursing Administrators add back	36,487	17	15
16	Deferred Maintenance Adjustment	(2,468)	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,874,132)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(47,232)	0	0	0	0	0	0	0	0	0	0	(47,232)	1
2	Food Purchase	(149,705)	0	0	0	0	0	0	0	0	0	0	(149,705)	2
3	Housekeeping	(209,598)	0	0	0	0	0	0	0	0	0	0	(209,598)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(291,821)	0	0	0	0	0	0	0	0	0	0	(291,821)	5
6	Maintenance	(341,495)	0	0	0	0	0	0	0	0	0	0	(341,495)	6
7	Other (specify):*	(83,528)	0	0	0	0	0	0	0	0	0	0	(83,528)	7
8	**TOTAL General Services**	(1,123,379)	0	0	0	0	0	0	0	0	0	0	(1,123,379)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(276,848)	0	0	0	0	0	0	0	0	0	0	(276,848)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(25,261)	0	0	0	0	0	0	0	0	0	0	(25,261)	19
20	Fees, Subscriptions & Promotions	(142,322)	0	0	0	0	0	0	0	0	0	0	(142,322)	20
21	Clerical & General Office Expenses	(222,469)	0	0	0	0	0	0	0	0	0	0	(222,469)	21
22	Employee Benefits & Payroll Taxes	(413,716)	0	0	0	0	0	0	0	0	0	0	(413,716)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(6,598)	0	0	0	0	0	0	0	0	0	0	(6,598)	25
26	Insurance-Prop.Liab.Malpractice	(2,900)	0	0	0	0	0	0	0	0	0	0	(2,900)	26
27	Other (specify):*	(177,092)	0	0	0	0	0	0	0	0	0	0	(177,092)	27
28	**TOTAL General Administration**	(1,267,206)	0	0	0	0	0	0	0	0	0	0	(1,267,206)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,390,585)	0	0	0	0	0	0	0	0	0	0	(2,390,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Moorings Health Center # 0045047 **Report Period Beginning:** 10/1/2000 **Ending:** 3/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(357,817)	0	0	0	0	0	0	0	0	0	0	(357,817)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(102,021)	0	0	0	0	0	0	0	0	0	0	(102,021)	32
33	Real Estate Taxes	(469,384)	0	0	0	0	0	0	0	0	0	0	(469,384)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(929,222)	0	0	0	0	0	0	0	0	0	0	(929,222)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,319,807)	0	0	0	0	0	0	0	0	0	0	(3,319,807)	45

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		McGaw Care Center	Evanston	Presbyterian Homes H	Evanston	Home Health Care
		Balmoral Care Center	Lake Forest	Presbyterian Homes H	Evanston	Hospice
		James C. King Home	Evanston			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	9	Medical Director	$ 43,864	Presbyterian Homes	100.00%	$ 43,864	$	1
2	V	17-3	Information Systems	10,807	Presbyterian Homes	100.00%	10,807		2
3	V	17-3	Overhead Administration	182,251	Presbyterian Homes	100.00%	182,251		3
4	V	17-3	Marketing	282,309	Presbyterian Homes	100.00%	282,309		4
5	V	17-3	Acounting Services	89,924	Presbyterian Homes	100.00%	89,924		5
6	V	17-3	Human resources	63,330	Presbyterian Homes	100.00%	63,330		6
7	V	17-3	Board Administration	3,578	Presbyterian Homes	100.00%	3,578		7
8	V	10a	Therapy Services	46,502	Presbyterian Homes	100.00%	46,502		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 722,565			$ 722,565	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	See attached listing of Board Members			None	None				$ None		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 9/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Presbyterian Homes
Street Address: 3200 Grant Street
City / State / Zip Code: Evanston IL 60201
Phone Number: (847.492-4800
Fax Number: (847.570-3426

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Medical Director	Direct Cost	1		$ 43,864	$ 21,202	0	$ 14,036	1
2		Information Systems	Direct Cost	1		10,807	4,308	0	3,458	2
3		Overhead Administration	Direct Cost	1		182,251	63,842	0	58,320	3
4		Marketing	Direct Cost	1		282,309	111,407	0	90,339	4
5		Accounting Services	Direct Cost	1		89,924	78,830	0	28,776	5
6		Human Resources	Direct Cost	1		63,330	43,949	0	20,266	6
7		Board Administration	Direct Cost	1		3,578	3,347	0	1,145	7
8		Therapy Services	Direct Cost	1		46,502	36,812	0	14,881	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 722,565	$ 363,697		$ 231,221	25

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Presbyterian Homes	X		Interest on Current Account			$	$			$ 102,021	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 102,021	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 102,021	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	121,109	2
3. Under or (over) accrual (line 2 minus line 1).	$	121,109	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,352	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	156,461	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999	242,217	11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Moorings Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045047

CONTACT PERSON REGARDING THIS REPORT Michael Geraghty

TELEPHONE 847.492-4873 FAX #: 847.570-3426

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-10-113-004-000	assisted living & health center	$ 121,109.00	$ 121,109.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,109.00	$ 121,109.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 115,857 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Moorings of Arlington Heights: Retirement Center, 294 Units; Square Footage: 325616
The Moorings of Arlington Heights: Adult Day Care Center; Square Footage: 2439
All expenses related to the retirement center have been adjusted out based on 68% of the census residing in the retirement community.
All of the Adult day care center expenses have been adjusted out of the cost report.
Food Service has been adjusted by 58% for the Retirement side.
Real Estate Taxes have been reduced by 75% for the retirement side.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2000	$ 759,549	1
2					2
3	TOTALS			$ 759,549	3

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		2000	1994	$ 8,615,818	$ 123,206	35	$ 123,206	$	$ 123,206	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Jensen Halstead Architects			2001	2,796	280	10	280		280	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,618,614	$ 123,486		$ 123,486	$	$ 123,486	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 832,804	$ 41,640	$ 41,640	$	10	$ 41,640	71
72	Current Year Purchases	23,703	2,370	2,370		10	2,370	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 856,507	$ 44,010	$ 44,010	$		$ 44,010	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,234,670	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 167,496	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 167,496	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 167,496	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Retirement Land	$ 1,614,043	$	$	86
87	Retirement Buildings	18,467,211	269,350	269,350	87
88	Retirement Equipment	1,793,040	88,467	88,467	88
89					89
90					90
91	TOTALS	$ 21,874,294	$ 357,817	$ 357,817	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

Presbyterian Homes employed the same trained staff that was in place when Advocate owned the moorings.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				3,983		3,983	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 3,983		$ 3,983	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Moorings Health Center **#** 0045047 **Report Period Beginning:** 10/1/2000 **Ending:** 3/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 3/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,406,817	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	565,573		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,972,390	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,373,592		13
14	Buildings, at Historical Cost	27,085,825		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,649,547		16
17	Accumulated Depreciation (book methods)	(525,314)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Current Accounts	(2,959,475)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,624,175	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,596,565	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 360,879	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	325,673		28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 886,552	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,800,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	27,097,195		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 28,897,195	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 29,783,747	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 812,818	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,596,565	$	48

***(See instructions.)**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	812,818	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 812,818	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 812,818	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,258,021	1
2	Discounts and Allowances for all Levels	(439,357)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,818,664	3
	B. Ancillary Revenue		
4	Day Care	64,130	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 64,130	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	59,732	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	22,567	15
16	Rental of Facility Space	4,488	16
17	Sale of Drugs	3,365	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 90,152	23
	D. Non-Operating Revenue		
24	Contributions	68,882	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68,882	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,041,828	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,475,421	31
32	Health Care	1,697,029	32
33	General Administration	1,754,249	33
	B. Capital Expense		
34	Ownership	1,253,179	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	49,132	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,229,010	40
41	**Income before Income Taxes (line 30 minus line 40)****	812,818	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 812,818	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	960	1,109	$ 43,044	$ 38.81	1
2	Assistant Director of Nursing	968	1,123	32,364	28.82	2
3	Registered Nurses	12,522	14,381	323,306	22.48	3
4	Licensed Practical Nurses	6,059	7,363	125,137	17.00	4
5	Nurse Aides & Orderlies	55,468	63,904	772,780	12.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,111	1,119	36,812	32.90	7
8	Rehab/Therapy Aides					8
9	Activity Director	952	1,104	19,398	17.57	9
10	Activity Assistants	6,252	7,268	83,990	11.56	10
11	Social Service Workers	944	1,042	21,028	20.18	11
12	Dietician					12
13	Food Service Supervisor	765	952	15,197	15.96	13
14	Head Cook	8,235	9,080	167,264	18.42	14
15	Cook Helpers/Assistants	32,706	35,289	365,643	10.36	15
16	Dishwashers	2,336	2,562	23,037	8.99	16
17	Maintenance Workers	9,090	11,064	203,551	18.40	17
18	Housekeepers	22,417	26,283	230,902	8.79	18
19	Laundry					19
20	Administrator	1,796	2,300	122,386	53.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,644	11,688	151,017	12.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	213	213	21,202	99.54	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	724	785	9,814	12.50	31
32	Other Health Care(specify)					32
33	Other(specify) Public Safety	7,754	8,811	92,357	10.48	33
34	TOTAL (lines 1 - 33)	181,916	207,440	$ 2,860,229 *	$ 13.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	240	22,500	9-3	36
37	Medical Records Consultant	40	1,851	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	25	1,000	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 25,351		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	849	$ 36,819	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	849	$ 36,819		53

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Young 2/2001-3/2001	H/C Admin	0	$ 14,395
Mary Fitzgerald	Director	0	68,728
Joanne Jurkovic 10/2000-2/2001	H/C Admin	0	39,263
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,386

B. Administrative - Other

Description	Amount
Overhead Department Administration	$ 74,119
Overhead Departments Accounting & Human Resources	126,073
Overhead Departments Computers & Board Relations	8,754
Overhead Department Marketing	253,599
TOTAL (agree to Schedule V, line 17, col. 3)	$ 462,545
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Malcolm James	Accounting	$ 7,749
Frost Ruttenburg & Rothblatt	Accounting	3,868
A.V.Powell	Accounting	995
Gardner Carton & Douglas	Legal	9,831
Smith, Hemmesch, Burke, Branning	Legal	10,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,443

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,774
Unemployment Compensation Insurance	
FICA Taxes	86,055
Employee Health Insurance	60,659
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement	33,532
Long Term Disability	601
Employee Meals	1,069
TOTAL (agree to Schedule V, line 22, col.8)	$ 194,690

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,074
Health Care Worker Background Check	
(Indicate # of checks performed 238)	633
Licenses, Inspections & Permits	894
Dues	4,535
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Moorings Health Center # 0045047 Report Period Beginning: 10/1/2000 Ending: 3/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Walk in Freezer Floor	1/2001	$ 2,302	3	$	$	$	$ 384	$ 767	$ 767	$ 384	$	$
2	Steam Well Units	2/2001	2,593	3				433	864	864	432		
3	Painting & Decorating	3/2001	2,385	3				398	795	795	397		
4	Formica Tops	3/2001	1,977	3				330	659	659	329		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,257		$	$	$	$ 1,545	$ 3,085	$ 3,085	$ 1,542	$	$

Facility Name & ID Number The Moorings Health Center **#** 0045047 **Report Period Beginning:** 10/1/2000 **Ending:** 3/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **22,351** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **49,132**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,341** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Reclassification Column 5 detail of schedule V

Adjustment detail of column 7 schedule V

Facility Name & ID Number The Moorings Health Center # 0045047 **Report Period Beginning:** 10/1/2000 **Ending:** 3/31/2001

Description	Column Reference	Amount
Employee Lunch Revenue	2	(3,341)
	22	3,341
Drug Purchases	10	(3,983)
	39	3,983
Advertising	17	(122,019)
	20	122,019
Yellow Pages	17	(146)
	20	146
Background checks	17	(1,979)
	20	1,979

Woorksheet 5A adjustment detail:

Description	Column Reference	Column 6 Amount	Retirement Reduction	Column 7 Adjustment	
Retirement expense Dietary	1	857,296	58%	(497,232)	
Food	2	258,112	58%	(149,705)	
Housekeeping	3	308,232	68%	(209,598)	
Utilities	5	429,148	68%	(291,821)	
Maintenance	6	491,969	68%	(334,539)	
Public Safety	7	122,835	68%	(83,528)	
Administrative	17	460,787	68%	(313,335)	
Legal	19	22,443	68%	(15,261)	
Dues Fees & Subscriptions	20	29,294	68%	(19,920)	
Clerical	21	293,974	68%	(199,902)	
Emplouee Benefits	22	608,406	68%	(413,716)	
Insurance	26	4,264	68%	(2,900)	
Depreciation	30	525,313	68%	(357,817)	
Real Estate Tax	33	625,845	75%	(469,384)	
This entry removes expense attributible to the retirement center.					
Deferred Maintenance	6	9,257	32%	(2,962)	
	6	1,545	32%	494	
68% was already removed for the retirement side with the above entry .					(2,468)
This entry takes the balance out and returns the appropriate percentage of the expense back.					
Kathy Young	17	14,395	68%	9,789	
Joanne Jurkovic	17	39,263	68%	26,699	
Add back the retirement side deducted above from the nursing administrators.					36,487
Line 20 items not taken off on schedule 5	20	28,548	68%	(19,413)	
To reduce the retirement side od dues, license, recruitment and background checks.					